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LEADING ARTICLES

THE OPEN OPERATIVE TREATMENT OF FRACTURES OF THE PATELLA.

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(Continued from page 464.)

Which is the most universally applicable of the three main types of operation that are now in vogue for the treatment of fractured patellae?

The results obtained by the employment of any of these three dissimilar operations, osseous suture, cerclage, suture des ailerons, have been, when the operations was performed by competent hands, so gratifying, that it is embarrassing to suggest that one of them be abandoned. With each of these different methods, excellent functional and anatomical recoveries have been obtained. Osseous suture has given satisfactory results. Cerclage has secured excellent recoveries. As to the third method, it has been truthfully said: "In fractured patellae, absolutely perfect results from the standpoint of contour, solidity and function have been obtained in a relatively short period, in cases in which all suturing was limited to the prepatellar and parapatellar fibrous tissues" (Peyrot). Whichever method be employed the repair of the soft parts is all-important. The importance of this step is emphasized by most of the advocates of osseous suturing. Baerlocher (17), Bockenheimer (19), Mikulicz (35), Oehlecker (36,) Trendelenburg (37), and others though they suture the bony fragments, never fail to supplement the latter step by suturing of the soft tissues.

In recent fractures of the patella, I have abandoned osseous suturing. I have not yet seen a case of old fracture of this same bone, in which I felt that a good result could not be obtained without the employment of osseous suturing.

To my mind, osseous suturing, as a method of treatment for fractures of this bone, has the following shortcomings.

A. It calls for special instruments.

B. The perforating instrument may break and the broken portion remain embedded in the patella. Annequin (38) reports a case of this nature. The drill broke and a fragment of it was left in the patella.

C. It is a procedure not universally applicable:

1. It is unsuited to the treatment of comminuted fractures.

2. It cannot be used to advantage in cases in which there is great inequality in the size of the fragments; one very large and one very small fragment. The lower and upper fragment may be that small that they could only afford an insufficient hold to the sutures. In cases of this description, many of the advocates of osseous suture resort to Quenu's "hemi-cerclage operation." In this operation, hemi-cerclage, the larger fragment is perforated transversely and the binding ligature is passed through this perforation and either through the ligamentum patellae or through the quadriceps extensor femoris, through the latter if the lower patellar fragment be perforated; through the former if the upper patellar fragment be the one perforated. Longitudinal suturing of the fragments, frequently owing to the unequal volume of the fragments or to their multiplicity proved to be a very difficult operation.

D. In cases of abnormally friable fractured patella, attempts to perforate the fragments, may provoke further splintering of the same (39). The slow elimination of splintered fragments prolongs convalescence, retards recovery.

E. In cases of secondary operation, the fragments may have become so atrophic that they are incapable of holding the sutures.

F. The proper boring in the patella, from before backwards, of channels for the introduction of the sutures, demands experience. At times it is difficult of execution. The perforation of the bony fragments always complicates and always lengthens the operative procedure.

G. It is needless. It adds injury to injury. Equally good if not better results are obtained by less difficult and less laborious methods.

Open circumferential looping was introduced by Berger (40), of Paris. It is employed by the advocates of osseous suture of fractured patella. In cases

1. In which one of the fragments is too small, to admit of perforation previous to the introduction of the silver wire, steel wire or other employed suture material.

2. In which one of the fragments is too small to be directly sutured to the larger fragment.

3. In fractures with many fragments or with comminution.

4. In cases of a normal friability of the patella. It has been and is still extensively employed in the treatment of fractured patellae, as (a) a supplementary measure to osseous suture; (b) as a preliminary, or as a supplementary measure to suture of the prepatellar and parapatellar tissues. By many it is employed as the only operative step in the treatment of fractures of the patella.

The advantages of circumferential looping or cerclage are (a) that its employment inflicts no additional traumatism upon the periosteal and osseous tissues. The osseous and cartilaginous surfaces are uninjured by the passing of the circumferential ligature. It respects the skeleton. (b) That the ligature material, which loops the patella, is totally extra-articular. It is introduced and embedded in the peripatellar tissues. Should a metallic ligature, such as silver wire, be used and its presence subsequently cause real or imaginary disturbances, the removal of the real or supposed offending agent can easily be effected without opening the articulation. It respects the articulation. (c) The method is of easy and of rapid execution. The maneuvers incident to its introduction are extra-articular. It can be used as a preliminary or as a supplementary step to any of the various open operative methods in vogue. It no doubt contributes to the exact coaptation of the bony fragments. As far as it goes, this procedure (cerclage) is safe, logical and serviceable. No special instruments are required for its performance. To our eyes circumferential looping as a method of treatment, has the shortcoming of insufficency. We use cerclage as a preliminary or as a supplementary measure to suture of the prepatellar and parapatellar tissues.

Study of the literature of the subject, surgical experience and clinical observation have led me to consider that the following are the most universally applicable operative steps to be conjointly employed in the treatment of such fractures of the patella as demand operative intervention.

1. The torn prepatellar fibro-periosteal sutures must be carefully sutured. E. Wyllis Andrews instead of uniting these torn prepatellar tissues end to end, sutures them in such a way that they overlap one another, that is, they are imbricated one within the other, "shingled as it were."

2. All tears in the parapatellar tissues must be sewed up. It is imperative that all capsular rents be carefully repaired. The suturing of the peri and parapatellar soft tissues has the approval of all clinicians.

3. To contribute to the maintenance in apposition of the fragments, the patella is circumferentially looped by a ligature passed close to its periphery. This ligature passed close to its periphery. This ligature is passed so as to be close to the periphery of the bone, so as to hug it as it were. It is inserted in such a way that it lies embedded in the substance of both quadriceps tendon and ligamentum patellae midway between their anterior and posterior surfaces. If deemed necessary, two such looping ligatures may be used. These different maneuvers are all extra-articular. In some comminuted fractures in which the interfragmentary diastasis was slight and in which the prepatellar tissues were practically untorn, I have often united the operative procedure to looping the patellar fragments and to fortifying the prepatellar tissues with a few V-shaped Kangaroo-tendon-sutures, not exposing the articular surfaces to inspection.

Should one, if he be an advocate of the open operative treatment, operate on the day, or on the morrow, of the infliction of the injury, or should he wait until the soft tissues have somewhat recovered from the immediate effects of the traumatism?

In all compound fractures of the patella, the time allowed to elapse between the injury and the operative intervention, should be the shortest consistent with the modern surgical preparation of the operative field.

In compound fractures of the patella, our practice is to have the patient conveyed at once to a well equipped hospital. Operation is performed soon after admission to the hospital.

The wisdom of operating immediately in compound fractures is, I believe, unquestioned. It is only in simple or subcutaneous fractures that there is great divergence of opinion among surgeons as to the elective time of operation; not only that, but many individual operators do not, as to the time-interval between injury and operation, observe a uniform practice. In subcutaneous fractures ample time should be taken for the preparation of the patient and of the surroundings for operation.

It has been our practice in fresh subcutaneous fractures of the patella, to defer operation for from three to five days after the injury, being guided somewhat by the patient's general condition and also by the evidences of local trauma. The congestion and inflammatory exudate consecutive to the injury have usually by this time begun to retrogress. Our results having been satisfactory, we are averse to change.

The time interval between the day of injury and the day of operation enables the surgeon to become better acquainted with the patient's general condition, to better familiarize himself with the type of fracture which confronts him, and to better asepticize his operative field. Owing to the wrinkled, thickened nature of the skin of the front of the knee, its surgical purification presents some difficulty.

Should the operative field be rendered bloodless by the employment of an Esmarch bandage? What should be the nature of the anesthetic employed? Local, lumbar or general anesthesia?

As a prophylactic measure against hemorrhage, or as an aid to secure a bloodless operative field, it is rare for surgeons to make use of the Esmarch bandage, or band, in their operations for fractured patellae Thienger (41) and Oehlecker (36) employ it. Its general non-use is evidence enough that clinicians do not consider it of any great assistance in these cases.

The Esmarch's brand, applied according to the ordinary rule, interferes, while in position, with the normal elasticity of individual muscles and of muscle group, may hinder the bringing down of the extensor muscles of the thigh, and consequently render difficult the approximation of the patellar fragments. The oozing into the articulation and tissues, that follows its use, is another undesirable feature attending its employment. We know of no valid reason for its preliminary use in operations for fractured patellae.

Chaput (31), Lotheisen (26c) and Stimson (13) have each with success, operated fractured patellae under local anesthesia. Chaput and Stimson used cocaine; Lotheisen employed Schleich's infiltration method. Ranzi (42) in one case resorted to anesthesia obtained by lumbar puncture and subarachnoid injection. Mickulicz in several cases used lumbar spinal anesthesia. Mayer (33b) also resorted to lumbar anesthesia.

In Chicago in operations of this nature, in the absence of contraindications, we almost invariably use general anesthesia. General anesthesia enables the operator to more thoroughly protect the patient from pain, to better guard against accidental septic contamination, to secure a more complete muscular relaxation, to proceed more deliberately, to modify his procedure so as to better adopt it to the needs of the case at hand.

Perusal of the literature shows that in these operations the employment of general anesthesia is in accord with the practice of European and American surgical centers.

By what type of incision is the operator best enabled to perform the repair work which he deems appropriate and necessary?

Large, methodically carried out incisions are infinitely less dangerous than small openings. The latter fail to fully expose the operative field, do not enable the operator to satisfactorily cleanse the joint and do not facilitate the careful repair of the lateral capsular and aponeurotic tears.

The single median vertical incision, unless it is made very long, does not admit of easy manipulation of the fragments. The freshening of the old cicatrized surfaces on both the upper and lower fragments either with saw or chisel, is not easily accomplished through it; it does not admit of easy cleansing of the joint. During kneeling, the scar is in the line of pressure, and, therefore, remains tender for an indefinite time. The H-shaped incision has objections. The scar lies directly across the patella.

In operating for fractured patella, I generally employ for the exposure of the parts, a flap having its convexity downwards. The incision commences on a level with the upper margin of the patella, about one inch to one side, from here it passes downwards to a point a little below the apex of the bone, from where it is continued across the limb, and carried to a point corresponding to that from which it started. This incision does not interfere in any way with healing (W. Jacobson and Rowland, 43). It is

thought that an incision with the convexity downwards, better secures the vitality of the flap than one with the convexity upwards.

These convex incisions afford a good exposure of the parts, facilitates the removal of intra and extra-articular exudates and extravasates, give good access to the bony fragments and allow of careful repair of all capsular pre- and parapatellar tears. If drainage of the peri-articular tissues is necessary, it is easily secured. With a longitudinal incision, drainage is somewhat difficult.

Is it advisable in these cases to irrigate the articulation; if so, with what fluid, an antiseptic solution, irritating or non-irritating, or merely a bland, non-irritating cleansing agent, such as normal salt solution, or is the mere sponging out from the synovial cavity of the extravasated liquid and clotted blood, productive of the most satisfactory results?

Joint irrigation with irritating antiseptics, such as carbolic acid and bichloride of mercury, we condemn. Any agent acting as an irritant upon joint endothelium, lowers its resistance to infection, predisposes it to inflammation. In flushings or irrigations of the joint cavities with normal salt solution, which solution is in itself unobjectionable, we fail to see much value. Of what advantage can it be to waterlog the tissues?

In operations interesting the pleural cavity, we do not irrigate that chamber to secure the outflow of any effusion collected in the pleural space. To accomplish this reliance is placed upon the elasticity of the chest-wall, the inspiratory expansion of the lung, the ascent of the diaphragm, and the use of a drainage tube. In operations upon the peritoneal cavity, we do not use this space to remove contained exudates and extravasates; we simply gently swab and mop.

In arthrotomy for fractured patellae we do not irrigate either the joint or the surrounding tissues. All liquid and clotted blood are removed by gauze swabs mounted on artery forceps. The swabbing is done with great gentleness, the object being to minimize the trauma inflicted. Scrupulous care is taken to keep the fingers out of the articular cavity. In formulating our conclusion we repeat that though we are aware that many clinicians, for instance, Ranzi, etc., prefer irrigation of the articular cavity to sponging of the articulation, we urge the discarding of joint irrigation and firmly advise dry sponging of the joint. Dry sponging for the removal of liquid and clotted blood from the articular cavity, is in these cases, productive of more satisfactory results. The sub-quadricipital synovial cul-de-sac is not to be overlooked, and all liquid and clotted blood therein contained must be removed.

Should non-absorbable or absorbable suture material be used? Are there any valid reasons for discarding non-absorbable suture material?

We refer here only to buried or irremovable suture material. If the suture material be so inserted as to be removable, once organic reunion of the divided tissues has taken place, it matters little (owing to the removability of the suture material) whether absorbable or non-absorbable material be employed.

In fractures of the patella it is not necessary that the fragments be held together with great firmness. Mere apposition is ample. Forcible tying of metallic sutures to some extent defeats its own purpose, as a suture drawn tight can cause in a bone, as well as in other tissues, a local pressure necrosis and absorption.

We consider it unwise to abandon non-absorbable suture material permanently in the articulation or in the peri-articular tissues, because:

a. Clinical observation has shown that metallic sutures frequently irritate the tissues (19), lower their vitality, increase chances of infection, and may require subsequent removal. In longitudinal suturing of bone, the twisted ends of the suture being almost immediately subcutaneous, kneeling is painful. To avoid this post-operative annoyance, some operators perform transverse suturing of the patella.

b. Metallic sutures may become loosened, may break, and fragments escape in the articular cavity by which they are poorly tolerated.

c. The embedding of wire sutures in the patella does not add to the solidity of the patella.

d. Non-absorbable sutures, be they inserted transversely or sagitally, cannot be considered permanent splints.

Von Brunn (44) as a result of his investigations came to the following conclusions:

1. Silver wire has not sufficient resistance to guarantee bony union of the fragments.

2. Even when the fragments are healed together, the wire may break.

3. Parts of the broken wire may wander into the articulation, or into the peri-articular tissues and can excite disturbances at point of lodgment. It has been claimed by Thiem, etc., that metallic sutures sugges-

tively hinder, in some patients, the cure of the subjective troubles.

Shall completely detached bony fragments be removed? If completely detached bony fragments be present, the removal is one of the essential steps of the operation.

It has been repeatedly done, and satisfactory results have ensued. The escape into the articulation of completely detached patellar fragments and their non-removal therefrom, leads to all the functional and anatomical articular disturbances inseparably associated with mobile foreign joint bodies.

Shall the periarticular tissues be drained? In order to allow the escape of excessive wound secretions many clinicians, Hackenbruch and others, though they did not resort to tube or gauze drainage of the periarticular tissues, always left the ends of the skin incision open. It did not unfavorably influence the ultimate results. In clean cases, subcutaneous drainage is needless. Its employment serves no useful purpose. It retards the healing of the skin wound. Why complicate an operative procedure by a useless step?

Shall the articular cavity be drained? In simple fractures, no. In compound fractures yes. Articular drainage should be discontinued as soon as the surgeon's fears as to the development of a suppurative arthritis have been dispelled.

The modern tendency is to employ drainage only in the presence of absolute indications; and to discard it when in doubt, as to its utility in the case at hand. When unneeded, drainage instead of contributing to rapid aseptic healing, has a tendency to act as an irritant. In the etiology of inflammation, irritants are considered predisposing and exciting factors.

What should be the nature and the duration of the post-operative treatment? As yet, the practice of the different operators as to nature and duration of post-operative treatment is most dissimilar. We proceed as follows: Immediately after the operative procedure and the application of the protective dressing to the wound and while the patient is still anesthetized, moulded plaster of Paris splint is applied to the injured extremity. This splint should be amply padded, should cover the posterior and arterial surfaces of the limb and should extend from about 10 c.m, above the external mallelous to the gluteal fold. The object of this splint is to immobilize the extremity in the position of full extension of the leg on the thigh, and of slight flexion of the thigh on the abdomen. The slight flexion of the thigh on the pelvis has for its purpose the relaxation of the rectus femoris muscle. During the patient's confinement to bed attention must be given to the heel and to the toes. So as to avoid the development of a pressure-sore upon former, the heel should be protected by a doughnut pad or other means. By the use of a cradle the toes will not be subjected to the weight of the bedclothes and talipes decubitus will not ensue. In the absence of a marked elevation of temperature, of intense pain, of saturation of the dressings, the protective gauze dressings on the joint remain undisturbed for from 10 to 15 days, then, if indicated, the removable sutures are ablated. The immobilizing splint is kept in position for about a month.

As to the duration of immobilization the practice of the various operators is far from being in accord.

The first motions of the patella should be lateral motions. We do not begin flexion of the leg upon the thigh previous to the expiration of one month from the day of the operation. The first attempts at flexion should be cautiously made. With use the range of motion gradually increases; in many cases, the restoration of joint function is complete. When flexion at right angle has been recovered, the patient is discharged from further observation.

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To develop manual dexterity nothing is better than the practice of tying surgical knots.—Amer. Jour. of Surg.

Guaiacol in Tuberculosis.—Guaiacol has been quite extensively substituted for creosote in the treatment of tuberculosis. This was suggested for the reason that the latter contains more than 60 per cent of guaiacol, which is more agreeable in odor, and taste, than creosote, and is said to be better borne. It improves the appetite and digestion, relieves flatulence, and is a pretty fair antiseptic. The dose is usually 3 to 5 drops. In daily quantities of from 20 to 40 drops it reduces hectic fever and modifies night sweats. When given in the early stages of the disease (tuberculosis) the bacilli diminish remarkably in number, and may in some cases entirely disappear. —Dr. E. L. Thorn.

SURGICAL EPONYMS.*

MARTIN HAGEN, M. D.

CHICAGO, ILL.

(Continued from page 357.)

Edebohls, George Michael (1853-1908), American; surgeon, New York. Operations: 1. Inverting the appendix into the lumen of the cecum. 2, Nephropexy, 3. Decortication of the kidney. 4. Panhysterocolpectomy.

Egeberg, Christian August (1809-1874), Norwegian; surgeon, Christiania. Operations: 1. Gastrostomy. 2. Method of treatiug esophageal stricture.

Ely, Edward Talbot (1850-1885), American; otologist, New York. Operations; 1. Auriculoplasty. 2. Skingrafting on granular surfaces in chronic suppurative otitis media.

Emmet, Thomas Addis (1828-). American; gynecologist, New York. Operations: 1. Perineorrhaphy. 2. Trachelorrhaphy. 3. Colporrhaphy. 4. Buttonhole operation for cystocele and urethocele. 5. Removal of submucous uterine tumors by morcellation.

Erasistratus, of Koes (3rd century A. D.), physician and surgeon at the court of Seleukos Nicator. Operations: 1. Division of the abdominal wall in diseases of the liver and spleen for local application. 2. Inventor of the urinary catheter.

Ericksen, Sir John (1818-1896), Danish; surgeon, London. Operations: 1. For nevus. 2. For varicocele.

VonEsmarch, Johannes Friedrich August (1823-1908), German; surgeon to the German army. Operations: 1. Osteotomy for ankylosis of the jaw, 2. Amputation of the foot. 3. Amputatiou at the hip-joint.

Estlander, Jacob August (1831-1881), Finish; surgeon, Helsingfors. Operations: 1. Thoracoplasty for empyema. 2, Cheiloplasty.

Fabricius. Gulielmus, [also called Hildemus (1560-1634)], German; surgeon, Bern. Operations: 1. Removal of particles of iron from the cornea by means of a magnet. 2. Amputations performed with a red-hot knife.

Farabeuf, Louis Hubert (1841-?), French; surgeon, Paris. Operations: 1. Amputation of the leg or arm at the "place of election." 2. Method of amputating finger or or toe. 3. Transcondyloid amputation. 4. Amputation of the thigh. 5. Disarticulation of the thumb. 6. Amputation at the elbow by the interior ellips. 7. Amputation at the elbow by a single external flap.

*Additions and corrections will be gratefully received.

8. Amputation through the surgical neck of the humerus. 9. Subastragaloid amputation. 10. Bi-pubiotomy.

Fenger, Christian (1840-1902), Danish. surgeon, Chicago. Operations: 1. Gastrostomy. 2. Incision for gastric operation. 3. Colpoplasty for atresia or defect. 4. For traumatic cerebral abscess.

Fenwick, George E, (1825-1894), Canadian; surgeon, Montreal, Operation: Excision of the knee-joint,

Fergusson, Sir William (1808-1877), Scotch; surgeon, London, Operations: 1. Incision for removing the snperior maxilla. 2. To bisect the upper lip. 3. Amputatiou through the foot. 4. Method of excision of the knee-and-hip-joints. 5. For double harelip. 6. Lateral lithotomy. 7. See Dieffenbach-Fergusson.

Ferri, Alfonsus (1515-1595), Italian; physician and surgeon to Pope Paul III. Operation, removal of bullets by the aid of a special forceps, later called the *alfonsium.*

Fine, Pierre (1760-1814), French; surgeon Paris. Operation, umbilical colotomy.

Fischer, Johann Nepomuk (1777-1847), Austrian; ophthalmologist, Prague. Operation, for stricture of the lacrymal duct.

Flajani, Joseph (1741-1808). Italian; physician and surgeon to Pope Pius VI. Operation, iridodialysis.

Flarer, Francesco (1791-1850), French; ophthalmologist, Paris. Operations: 1. For trichiasis. 2. For cicatricial entropion.

Forster, John Cooper (1824-1896), English; surgeon, London. Operation, gastrostomy.

Fouillioy, Louis Mathurin (1790-1848), French; surgeon, Paris. Operation, disarticulation at the hip-joint.

Franco, Pierre (1505-1562), French; surgeon, Friburg. Operations, 1. For double harelip. 2. Suprapubic cystotomy.

Frère, Come (1703-1781), French; surgeon, Poyestrue. Operation, high lithotomy.

Frère, Jacques. See Baulot.

Freund-Wertheim, q. v. Operation, for prolapsus uteri.

Freund, Wilhelm Alexander (1833-), German; gynecologist and obstetrician, Strassburg. Operations: 1. Laperohysterectomy. 2. Perineorrhaphy. 3. See Freund-Wertheim. 4. See Veit-Freund.

Fritsch. Heinrich (1844-?), German; obtetrician, Breslau. Operations: 1. Colpectomy. 2. Method of incising the uterus in Secarian section. 3. Vaginal hysterectomy.

Furnari Salvatore (?-1866), Sicilian; ophthalmologist, Palermo. Operations: 1. Iridectomy. 2. For pannus.

Galbiati, Gennaro (1776-1844), Italian; obstetrician, Naples. Operations: 1. Bi-ischiopubiotomy. 2. Symphysiotomy.

Gale, Thomas (1507-1587), English; military surgeon. Operation, demonstrated the non-poisonous character of wounds inflicted by gunpowder or bullets.

Galen, Claudius (130-200), Greek; physician and surgeon to the Emperor of Rome. Operations: 1. Ligation of arteries in continuity. 2. First to mention trephining of sternum for empyema or mediastinal abscess.

Galezonski, Xavier (1833-1907), Russian; ophthalmologist, Paris. Operations: 1. Extraction of a cataract. 2. For pterygium. 3. Synechotomy.

Garengeot, Rene Jacques Crousant (1688-1759), French; surgeon. Paris. Operations: 1. Perfecting the ordinary flap amputation. 2. Amputation at the shoulder-joint.

Garretsou, James Edmund (1828-1895), American; oral surgeon, Philadelphia. Operation, staphylorrhaphy.

Gély. Julius Aristide (1806-1861), French; surgeon, Paris. Operation, method of enterorrhaphy.

Gensoul, Joseph (1797-1858), French; surgeon, Lyon. Operations: 1. Dicision of the superior maxilla by a special incision. 2. For double harelip. 3. For stricture of the lacrymal duct.

Gerdy, Pierre Nicolas (1797-1856), French; surgeon, Paris. Operations: 1. For entropion. 2. Herniotomy. 3. For stricture of the lacrymal duct.

Gibson, William (1788-1868), American; surgeon, Philadelphia, Operations: 1. Ligation of the common iliac artery. 2. Cecostomy for direct medication of the colon.

Gillespie, James Donaldson (1823-1891), Scotch; surgeon, Edinburg. Operation. excisiou of the wrist.

Gioppi, Giauantonio (?-1872). Italian; ophthalmologist, Padua. Operation, for cataract.

Giraldes, Cardozo Cazado Joachim (1808-1875), Portugesian, surgeon, Paris. Operation, for single complete harelip.

Goyrand, Jean Gaspard Blaise (1803-1866) French; surgeon, Paris. Operations: 1. Ligation of the internal mammary artery. 2. For Dupuytren's contraction.

Von Graefe, Friedrich Wilhelm Ernst (1828-1870), German; ophthalmologist, Berlin. Operations: 1. Uranoplasty. 2. For cataract. 3. For keratocount. 4. For dacryops. 5. For ectropion. 6. For entropion. 7. Evisceration. 8. Eor fistula of the lacrymal gland. 9. For prolapse of the lower lid. 10. For ptosis. 11. For retinal detachment. 12. Rhinoplasty. 13. For single harelip. 14. For staphyloma. 15.

Strabotomy. 16. For trichiasis. 17. See Graefe -Romberg.

Graefe-Romberg, q. v. Operation, for blepharospasm.

Gross, Samuel D. (1805-1884), American; surgeon, Philadelphia. Operations: 1. Amputation of the foot. 2. Amputation of the great toe. 3. For varicocele.

Gross, Samuel Weissel (1837-1889), American; surgeon, Philadelphia. Operation, internal urethrotomy.

Grube, Wilhelm Sigismund (1827-1898), Russian; surgeon, Kharkov. Operation, for ankylosis of the inferior maxilla.

Guerin, Alphonse (1816-1895), French; surgeon, Paris. Operations: 1. Amputation at the elbow. 2. Partial excision of the superior maxilla. 3. For carbuncle. 4. Iridotomy. 5. For naso-pharyngeal polypus. 6. Subconjunctival strabotomy.

Gussenbauer, Carl (1842-1903), Austrian; surgeon, Prague. Operations: 1. Method of closing rent in intestine. 2. Meloplasty. 3. Paracentesis pericardii.

Guthrie, George James (1785-1856), English; surgeon, London. Operations: 1. Amputation at the surgical neck of the humerus. 2. Amputation at the hip-joint. 3. Ligation of the first part of the axillary artery.

(To be continued)

Alcohol as Medicine.—As to alcohol's place in therapeutics—I truly believe, nay, I am sure—we could well dispense with it and use more potent and far safer agents which, as stimulants, will carry our patients along or tide them over momentary decline.—Dr. S. P. Goodhardt.

Coryfin in Polynasal Catarrh.—One of the newer German preparations on the market is coryfin (ethylglycolic acid ester of menthol). The solution is colorless, almost odorless, and forms a very stable menthol combination. In too great amounts it apparently has irritating qualities, for it sets up a series of paroxysms of sneezing. In the form of a spray it is an ideal and soothing medicament. The vapor apparently deliquesces by adding itself in the nose, and within a short time after its application the menthol is gradually eliminated, so that the effects of a very small amount of the drug will last for hours. Its special benefit is seen at night. If used before retiring, the nose will feel clear, nasal respiration will not be obstructed, and the head will feel relieved of the heaviness which generally accompanies polynasal catarrh.—Hays.

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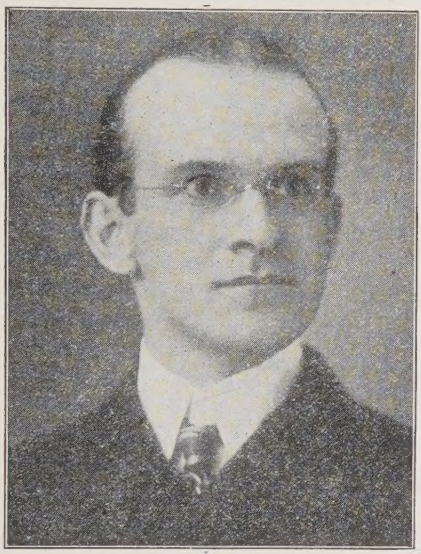
EDITORIAL

The M. V. M. A. Meeting.

The St. Louis profession is feeling a pardonable degree of satisfaction in the carrying out of its plans in the recent meeting of the Mississippi Valley Medical Association; the meeting was a pronounced success in its scientific and social endeavors. While not so large an attendance was attracted as had been hoped the registration was up to the average of recent years, and the attendance of nonmembers made the audiences large at every session. The scientific work presented justified all that was said in anticipation of the programs, it was a scientific feast. Better programs were never prepared and the features announced before the meeting fulfilled the desires of the most exacting. With one exception the entertainment features were brilliantly successful; the local profession has no responsibility in the matter of the river excursion proving so dismal a failure. It has taught us that we must, upon future occasions of the kind, place no dependence on entertainment offerings which are not directly under the supervision of our own committees. The St. Louis profession feels that an apology is due those who availed themselves of the invitation on this occasion, the success of every other entertainment feature being sufficient warrant of our sincerity in the matter.

Aside from the scientific and social endeavors considerable interest centered in the business affairs of the Association. We have known little of the conduct of this body during reecnt years, and we had labored under the mistaken notion that it was the most democratic of medical organizations; in so far as the fact goes the rank and file of the membership have practically nothing to do with its control and government, and democratic is misapplied when associated with the M.V.M.A. The associa-

tion is splendidly officered, and the fact of continuance in office of any officer is not to be mentioned by us as anything to his detriment, but we feel that no individual as an officer is absolutely essential to any organization, and that the progress of the body would be materially advanced by occasional change. Were we planning the organic law of any body we would make it impossible for any officer to hold office continuously longer than three years. Such a body as the M.V.M.A. has in it many men who could so speedily master the details of the situation that there would be no disadvantage to the association in the change, there would be advantage for the interest of different groups would be increased and the benefit would be general.



DR. FRANK PARSONS NORBURY
President-elect Mississippi Valley Medical Association.

The present plan leaves the work in the hands of a few capable men who seem so essential after their years of service that one wonders what would be the fate of the association were they suddenly to withdraw. We are not advocates of too frequent change, but we do believe that every position should be represented by several ex-officials within the body at all times.

The refusal of the association to hear Dr. Lydston's paper is a matter of wisdom which is open to question, not having heard the paper we are as unable to express opinion as to its contents as were those who rejected it; its rejection emphasizes the very position which the doctor and others are opposing, that independence is to be stifled, and that any questioning of the powers-that-be is not to be countenanced. Dr. Lydston announces himself as ready to be held legally responsible for his utterances and denying him a place to speak is an acknowledgement of weakness unless it is positively known that he has items in his paper which are open to legal objection and legal redress. It has made ammunition for the independents, if they are to be so styled, and hurt the association more than the reading of the paper ever would have done.

We of the Fortnightly are naturally pleased with the selection of Dr. Frank Parsons Norbury as the next president; Dr. Norbury was so long our editor and is so well known to our readers that we feel that we express the opinion of all our readers in predicting an administration of exceptional excellence and a year of real advancement for the association.

The election resulted as follows: President, Frank Parsons Norbury, Kankakee, Ill.; first vice-president, George W. Cale, Jr., St. Louis; second vice-president, William V. Laws, Hot Springs, Ark.; secretary, Henry Enos Tuley, Louisville, Ky.; treasurer, S. C. Stanton, Chicago.

Detroit was selected as next place of meeting.

Medieval Torture and 20th Century Law.

There are few urban dwellers who have not been shocked from time to time by reports of atrocities perpetrated under the so-called "third-degree" by officials in their endeavor to gain from supposed criminals a confession; during the past week the daily press has told of another instance of the kind which occurred in East St. Louis. The detectives of that city had apprehended a burglar; immediately every unexplained crime for some time back was attributed to him and, in relays, they began the "third degree" keeping the unfortunate awake and under a fire of continuous interrogation for ninety-odd hours when he was allowed to sleep for a half hour and then the inquisition was resumed for how long is not announced. Whether the unfortunate became a gibbering idiot or confessed to anything he was asked, is also unannounced, but a man who has been through such a torture ought to be ready to confess to almost anything, and the confession ought to be worth nothing as evidence in law.

We have supposed it a fundamental principle in American law that a man is sup-

posedly innocent until he is proven guilty, we have yet to discover where the detective forces of the various American municipalities have gained authority to secure alleged confessions through the instrumentality of torture. And such torture, the thumb screws and the wheel are a kindness in comparison! Such methods make criminals and anarchists.

It is a necessity that police officials deal with crime with an iron hand but it is not for them to inflict such punishments as these simply because they hope to gain a confession. One of the chances one takes in living in the safety of modern civilization is that he may be accused of an infringement on the law; he may be arrested, but he is not guilty until he is proven so. The fact of his guilt in one case does not make him bound to confess sins of which he has never dreamed. Four days of ceaseless interrogation, without sleep, and then more of the same, and that in all probability relative to offenses about which the man knew nothing seems to call for some explanation from those who were responsible for it. Were he guilty of all things that are attributed to him it would still be inexcusable.

This is a matter for medical men to consider as individuals and as men who mould public sentiment; who know the possibility of serious physical and nervous consequences to the unfortunate wretch. The third degree except in its milder forms should go, and in its milder forms it should be but rarely resorted to.

Superintendent Norbury of Kankakee.

A general satisfaction is felt in the profession over the appointment of Dr. Frank Parsons Norbury to the important position at Kankakee. The profession of his home city, Jacksonville, Ill., are especially pleased with the choice, though regretful that so useful a member of the medical and civic community is taken from them. Close on the heels of this appointment came Dr. Norbury's elevation to the presidency of the Mississippi Valley Medical Association. These merited honors will be borne by the doctor with the same dignity and modesty that have characterized his life and which have led to his receiving them.

Before leaving Jacksonville the profession of that city tendered him a testimonial banquet of which we have received the following brief report, we having, unfortunately been hindered from being present:

A FAREWELL TRIBUTE.

When a man has wrought long and so well that his talents shine out with such extraordinary brilliancy that the commonwealth in which he is a citizen calls him to a position high in her service, it is but meet that his colleagues among whom he has lived and labored day by day, should hasten to do him open honor and mingle regrets at his parting with their heartfelt joy at his achievements and recognition.

Such an event happened the other day at Jacksonville, when the Morgan County Medical Society and Jacksonville Medical Club gave a testimonial banquet in honor of Dr. Frank Parsons Norbury, who has recently been chosen to be superintendent of the Kanakee, Illinois, State Hospital.

Close associates of the honored guest from Missouri, Iowa, Chicago and throughout Illinois, were invited to be present on this occasion.

The grave and the gay in the hearts of all present were fully covered in the spoken testimonials by the Reverend Roswell O. Post, Jacksonville; the worthy toastmaster, Dr. Carl E. Black, Jacksonville; Dr. L. J. Harvey, Griggsville; Hon. Wm. C. Graves, Springfield; Dr. James F. Percy, Galesburg; Dr. L. C. Taylor, Springfield, and Drs. A. L. Adams and T. J. Pitner, Jacksonville. Dr. Norbury responded to the sentiments of regard for his many sterling qualities of noble character with deep feeling. Many testimonial letters, telegrams and cards of regret were received, some of which were read.

All present felt the great import of the event and that a really good and great man was being paid sincere tribute by his fellows.

Dr. Norbury had a few days previously, been presented with a loving cup by his fellow-members of the Jacksonville Medical Club.

ST. LOUIS ITEMS.

Dr. W. T. Elam, of St. Joseph, spent seval days in St. Louis recently.

Dr. and Mrs. W. B. Clarke are rejoicing in the arrival of a daughter.

The addition to the Baptist Hospital, which we mentioned some time since, is nearing completion. It will double the capacity of the hospital and is an excellent example of hospital construction. Ultimately the older building will be replaced by one harmonious in style with the new wing.

DR. JABEZ N. JACKSON
KANSAS CITY
President Medical Association of Southwest.

Dr. Mary H. McLean has lately returned from some months spent at European medical centers where she devoted her attention to surgical gynecology and pathology.

A change in the staff of St. Mary's Hospital, recently announced, seems to promise an era of increased usefulness to that institution. Drs. Louis Rassieur and John Mc H. Dean are now surgeons-in-charge.

Dr. Cook's lecture in St. Louis was the event of the Centennial week. The doctor's address left his many thousand hearers with no doubt whether or not he ever reached the pole; it was absolutely convincing.

The M. V. M. A. brought so many medical friends to St. Louis, and their stay was so pleasant for us that we are again impressed with the fact that such gatherings have an importance even greater than that which is measured by the scientific work done.

Mr. Otto F. Kerschel, for many years connected with the Blees-Moore Surgical Instrument Co., has severed his connection therewith and has established himself independently at 309 Mermod-Jaccard Bldg. Mr. Kerschel will handle standard lines of trusses and supporters and surgical and hospital specialties. His friends in the profession are many and his venture promises abundant success.

CENSUS COMMISSION REPORT.

Washington, D.C., October 15, 1909.

The preliminary report of the Census Commission relative to the second decennial revision of the Classification of the Causes of Death, made by the International Commission in Paris recently, together with the revised list of titles will be found in Census Bulletin No. 104 which will be published soon and copies will be sent to all of the registration officials of the United States and to the members of the American Statistical Association. A new manual of classification will be prepared for the use of the registration offices of the United States as soon as the detailed results of the revision are available, and an effort will be made to bring the revised classification to the attention of every physician and local registrar in the country as an aid to the proper reporting of causes of death.

If the Census Commission had accomplished nothing in the way of practical reform, it would have been, according to Census Chief Statistician Wilbur, well worth sendiing order that the country should occupy the place to which it is entitled in the councils of the nations which employ this classification; but, as a matter of fact, very much was accomplished.

Dr. F. P. Foster, as chairman of the American Medical Association's committee and Dr. Wilmer R. Batt, as chairman of the committee of the American Public Health Association, have been engaged for over a year in co-operation with the Bureau of the Census and with committees appointed by many national medical organizations devoted to special branches of medicine, upon the question of the proper classification and nomenclature of the diseases with special reference to the improvements to be made in the International Classification at the recent revision. Meetings were held by these committees at Philadelphia New York, and Washington, and important suggestions were formulated which were duly transmitted to the Secretary-General, Dr. Bertillon, and were laid before the commission in the special book prepared for its use. A very considerable proportion of these was adopted by the International Commission. Perhaps the most important of all the measures specially recommended by the United States was the improvement in the principle of the statistical classification of deaths from violence. Dr. Bertillon, Dr. Livi of Italy, and Dr. Cressy L. Wilbur were appointed a special committee of the commission to adjust this

portion of the classification, which they did.

Dr. Wilbur stated today that he believed the revised list will be more acceptable to American registrars and that it will give the information in regard to the industrial causes of mortality in a more satisfactory way than any classification previously prepared. Of course all of the recommendations of the American delegates could not be adopted. There were 23 countries represented in the International Commission and conservatism is a characteristic of European officials and especially of European statisticians It is perfectly right, he declared, that this should be so because it creates endless confusion when many changes are made in an established system of compilation Furthermore, it is hardly to be expected that a country like the United States, whose registration officials had never before joined in an international congress and whose statistics relate to only about one-half of the population of the United States should be able to prevail against the established views of the representatives of countries where complete and comprehensive vital statistics have been published for a long series of years. Nevertheless the fullest consideration was given to the American propositions and the utmost courtesy and harmony prevailed. He feels that the American delegates owe profound thanks to the Secretary-General, Dr. Bertillon, and to the French government, and that American registrars should loyally abide by the recommendations adopted and use the International Classification without any modifications or changes, except such as are entirely permissible under its constitution, for the next ten years.

Dr. Wilbur stated that the United States starts at the beginning of a new census decade with the revised classification of causes of death, in which American registration officials and American physicians have had their say; a revised standard certificate of death, which will be adopted by the American Public Health Association at Richmond this month, and put into effect for all of the registration area beginning January 1, 1910; and with new rules and instructions recently formulated by the Director of the Census and promulgated to all reporting offices for the purpose of obtaining more complete and correct transcripts of the deaths now registered.

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MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

THERAPEUTICS.

C. W. HEPBURN, M. D.

The Enzyme Treatment for Cancer—Final Report. In a previous paper, "Trypsin in Cancer, a Preliminary Report," published in March, 1907, Dr. William Seaman Bainbridge expressed the determination of giving to the "enzyme treatment," as outlined by Dr. John Beard of Edinburgh, a thorough, scientific test, in a sufficiently large number of cases and over a long enough period of time, to warrant some claim to finality when conclusions were drawn. This he has done and communicates the result to the Medical Record for July 17, 1909. He says: "Now, after an interim of more than two years since the 'preliminary statement' as made, and full three years since I began to employ the enzyme method, it would seem that a final report may be offered which will meet the requirements of what may be called a 'fair test.' The New York Skin and Cancer Hospital furnished ample clinical material from which to draw a large proportion of the cases in which the method was tried, and an enormous amount of time and patience and much money were necessary in following out the details of the treatment. The materials employed were: (1) Holadin capsule, a pancreas gland extract containing all the pancreas enzymes —trypsin, amylopsin and lipase—and the milk-curdling ferment. This was given to aid digestion. (2) "Pepule" oxgall compound, which contains inspissated oxgall, extractum pancreatis, and extract of nux vomica. This to give tone to the bowel and aid in elimination. (3) Lotio pancreatis a glycerin extract prepared directly from the fresh gland and carrying in solution the entire soluble gland constituents. This solvent of broken-down tissue was applied topically to the ulcerating surfaces. (4) Injectio trypsini, a glycerin extract of trypsin, which, according to Beard, was supposed to "kill" the cancer cells. (5) Injectio amylopsini, a glycerin extract of amylopsin, which was thought to "digest" the dead cancer cells. Blood examinations were made in a number of cases to observe what effect, if any, the treatment had on any anemia present, or on the white blood cells, and ordinary urine tests were made in 23 cases treated with trypsin to ascertain if it exerted any irritating action on the kidneys. In summing up, the

author gives his conclusions in thirty numbered paragraphs, of which the last three are the most significant: (28) That the enzyme treatment as administered in the cases herewith reported, and according to the suggestions of Dr. Beard, plus important details of regime, does not check the cancerous process. (29) That it does not prevent metastasis. (30) That it does not cure cancer."

A Case of Acute Veronal Poisoning.—Dr. John L. Eckel gives an interesting account, in New York Medical Journal for July 17, 1909, of a case of acute veronal poisoning. The man, on admittance to the hospital, thirty hours after he had taken 110 grains of the drug with suicidal intent, was in a profound sleep, from which he could not be aroused more than to move an arm or leg; his temperature was 98.4 deg. F., pulse 88, respiration 20, blood pressure 130 mm. of mercury. Face slightly flushed, skin moist, deep reflexes retained, corneal and skin reflexes abolished; pupils slightly contracted but reacted to light, had retention of feces and urine. Examination of a catheterized specimen of the urine showed nothing abnormal. The deep sleep continued for about twenty hours after admission, when he began to move about, open his eyes and make inquiries as to where he was. He was very drowsy and answered questions with difficulty. The drowsiness gradually cleared up, his appetite returned, control of bowels and bladder was regained, and by the seventh day patient was apparently normal. He has shown no untoward symptoms since. No treatment was given except catheterization and rectal enemata. The clinical picture of veronal poisoning is profound sleep, with good heart and respiratory activity, abolished corneal and skin reflexes, with persistence of pupillary and tendon reflexes. Absolute certainty of diagnosis can only be had by the extraction of veronal from the urine with ether. The ether is then evaporated, and the resultant crystals will melt at about 185 deg. C. Mild cases get well without treatment. If seen early, stomach lavage should be practiced. Castor oil and enemata are indicated for the bowels; when necessary, urinary flow must be kept up by hypodermoclysis; cardiac and respiratory failure calls for caffeine or camphor, with warm baths or cold sponges as adjuvants. In 10 cases of acute veronal poisoning collected by Steinitz, in which the quantity taken ranged from 45 grains to 5 drachms, those who took 75 grains or less, recovered in about three days; those who took 75 grains and less than 2½ drachms, in about ten days; more than 2½ drachms usually proved fatal.

High Caloric, Low Nitrogen Diet in Typhoid.—In an interesting paper in Post-Graduate for July, 1909, Dr. Harris A. Houghton says the ideal food for the typhoid patient should strive to meet the needs of the organism as regards increased tissue waste and increased heat production, but as they are ordinarily fed—with milk, peptenoids and similar preparations—they get less than half enough to produce the required amount of heat, and largely in the form of protein. As a result, we see in a large majority of "normal typhoids" a mixed toxemia. One is that of the disease itself, and one an intoxication which is generated in the intestinal tract in the contents of the tube. He presents cogent and conclusive reasons for his belief that cow's milk does not fulfill the needs of the patient, who should receive food of the dynamic value of about 2800 calories, and suggests the following diet as meeting the requirements. It is composed of one-tenth protein, two-tenths fat and seven-tenths carbohydrate, and has the dynamic value of (about 2700 calories. It is given in hourly doses or every two hours, so that the digestive powers are not called upon for much at any one time. A ten hour rest is given at night. 6 a.m. Two thin slices, well toasted stale bread, with crust cut from ordinary sized loaf. Coffee, two flat teaspoonfuls sugar and 2 tablespoonfuls cream. 8 a.m. Oatmeal gruel, containing 2 oz. (before boiling), strained. Small handful of crackers or a Huntley and Palmer biscuit. 10 a.m. Soup containing 3 oz. (before cooking) well boiled rice. Sugar of milk, 2 flat tablespoonfuls. 12 m. Moderate sized baked potato, thoroughly cooked, mashed and creamed, 2 slices of toast, butter to taste and tea with sugar and cream. 2 p.m. Tapioca pudding containing 2oz tapioca (before cooking) and 2 teaspoonfuls milk sugar. 4 p.m. Soup containing 3 oz. (before cooking) well boiled rice and 2 teaspoonfuls milk sugar. 6 p.m. Two slices toast and butter or zweibach, half cup tea and teaspoonful of sugar. Other starch foods may be substituted to afford variety and the amount given should be guaged by the condition and desire of the patient. It is not said, as yet, that his diet will lower the death rate from typhoid still further; but it is claimed that there will be a great reduction in toxemia.

The Thyroid Preparations in Practice.—Dr. Charles E. de M. Sajous says, in Gail-

lard's Southern Medicine for July, 1909: "Probably the most striking evidence of the value of our remedies, and one which controverts most emphatically the pessimistic tendency of our day, is that afforded by the use of thyroid extract in cretinism or—a better term—infantile myxedema," and quotes Osler's description of an aggravated case of the disease and the magic change effected by the administration of thyroid. The functions of several ductless glands are more or less related and the author's researches show that three of them, the thyroid (including the parathyroids), the pituitary, and the adrenals, are connected by nerve paths and act jointly to produce in the blood—and demonstrated three in all—the active agents concerned with metabolism, nutrition and immunity, the identity and source of which have remained obscure: an increase (1) of adrenal oxidizing substance (the albuminous constituent of hemoglobin and Ehrlich's amboceptor); (2) of thyroid sensitizing substance (Wright's opsonin); (3) of trypsin (Ehrlich's complement and Metchnikoff's cytase); and (4) bacteriolytic leucocytes (Metchnikoff's phagocytes). In view of the above we can understand the action of the thyroid preparations in disorders of nutrition and those due to toxic waste products, in infectious diseases and in diseases due to deficient reparative power. The average dose recommended in the Pharmacopeia, 4 grs., is too large. With most adults the author rarely finds it necessary—except in the treatment of obesity—to give more than 3 grs. during each meal, beginning with 1-gr. doses and increasing very gradually. Dr. Sajous pointed out, in 1903, that cancer was due to deficient immunizing activity in the blood, owing to the deficiency of the very four constituents which the thyroid preparations supply. Of its use in this dread disease he says: "Many cases are on record in which thyroid preparations have failed to do good; worse than this, it may be said that in these cases it actually did harm! But study these cases as I have, and you will see that the clinicians who obtained such results acted on the belief that since a small quantity does good, a large quantity must do more good. The results under such conditions are self-evident; the doses administered were not the small ones which enhance nutrition and the activity of the reparative processes, including the preliminary breaking down of cellular aggregates that are useless to the needs of the body, but the large doses that destroy not only the malignant growth itself, but the body as well."

SOCIETY PROCEEDINGS.

AMERICAN PROCTOLOGIC SOCIETY.

Eleventh Annual Meeting, held in Atlantic City, June 7 and 8, 1909.

(Continued from page 416.)

Appendicostomy as an Aid to the Treatment of Malignant and Intractable Dysentery.—(John L. Jelks, M. D., Memphis, Tenn,)—In reference to this subject, the author stated that when amebic infection had become very chronic or had extended into all the parts of the colon beyond the use of local measures, and, in some instances, of acute malignant cases, appendicostomy should be performed and irrigation practiced through the appendiceal stump. The water is allowed to pass out through the rectum into a catch-basin and is not an unpleasant method of treatment. Dr. Jelks prefers the method suggested by Dr. James P. Tuttle, of New York City, who conceived the plan of allowing the appendix to remain undisturbed after anchorage, for a sufficient time, (three or four days), to establish adhesions about the proximal end, before cutting away the distal portion and using the appendiceal stump-lumen through which to irrigate with the desired solutions. Dr. Jelks practiced this method and irrigated the colon with formalin-boric, copper-phenol-sulphonate, quinine and normal salt solutions with gratifying results. It was observed, however, that irrigations thus given did not effect a cure. Topical applications (per sigmoidoscope or rectoscope) were in all cases used in conjunction. The method as used by Weir, and as advised by Tuttle, is practically free from danger, and the author believes is not more hazardous than appendicostomy and the after effects are not at all unpleasant to the patient in the ways and degrees that a colostomy must be. He sees no great danger of hernia or wound infection if proper precautions are taken in dressing the same. By this method one may practice almost continuous irrigation of an inflamed colon and rectum with no special degree of pain or discomfort to the patient, the appendix being used as a nozzle directing the solution into the colon. He does not advise appendicostomy except in a small percentage of cases, mostly chronic ones, but in these, he insists that it is a most valuable aid to treatment and that the operation itself is practically free from danger, as is appendectomy when the appendix is not the seat of infection. The author concludes his article by stating that in all cases requiring appendicostomy we should not permit the stump to close before the expiration of one year. He has been forced to

reopen an appendiceal stump three months after closure and resume irrigations. This was accomplished in his office, bui it may become a very difficult matter to find the lumen of a closed appendix.

Primary Gonorrhea of the Rectum in the Male.—(Alfred J. Zobel, M. D., San Francisco, Cal.)—The writer stated that a review of the literature for the past five years showed very little to have been written on the subject of rectal gonorrhea, and the cases reported have been rectal gonorrhea in the female and for the most part secondary to an infection of the genital tract. It was also stated that gonorrhea of the rectum in the male is almost always the result of sodomistic practices, and when so can be considered of the primary type. The condition has been rather rare in this country but since the influx of foreigners from those countries where unnatural practices are common, more cases are now seen. The cases reported by the writer were seen in the rectal clinic at the San Francisco Polyclinic and were in American born boys of 16, 18 and 20 years of age, respectively. They belonged to the tramp class and were of a rather low order of intelligence. They were ignorant of their true condition and came to the clinic with a self-made diagnosis of "piles." When made aware of the true nature of their trouble it had a markedly depressing effect upon them, which in one case, after a few weeks, developed into a condition resembling the neurasthenia which often accompanies a chronic posterior urethritis. The symptoms complained of, briefly summarized, were:—all complained of such soreness about anus and rectum that they did not dare to stand; while walking was an effort and caused great pain, At the time of bowel movement they suffered such excrutiating pain that they hesitated to pass their feces, and had become quite constipated. Two were annoyed by discharge from the anus, while one was unaware of its presence, although it was found on examination. In one, the discharge was streaked with blood, and bleeding was noticed at the time of defeation. One complains of an itching sensation about an inch up from the anal aperature., and had severe pain on the drawing in of the anal sphincters. Their appearance was feverish, worried and haggard, and they felt weak, ill and distressed. It was impossible to make a digital or instrumental examination at the first visit on account of the severely acute pain caused thereby. Therefore, whenever there is the least suspicion of the visribility of a specific inflammation of the anus and rectum the case should be treated as if it actually exists, and the ultimate diagnosis left to the future. When the acute symptoms have subsided under treatment, there can be seen excoriation and fissures about the anal orifice and in the canal, with marked redness and infiltration of the mucous membrane of the anus and rectum, together with the presence of a purulent secretion. Examination of this secretion shows the presence of the gonococcus. The author believes that gonorrhea of the rectum in the male is a much more common condition than is suspected by the general profession. Many of the latter even do not know that such a condition could exist. The treatment is directed towards keeping the parts clean; relieving the severe rectal symptoms; reducing the inflammatory exudates; keeping the fecal movement solt; healing the ulcerations and destroying the infective agent. The author further brings out the important point, which he deems worthy of consideration, that there seem to be no reasons why complications, such as gonorrhea arthtrtis or an endocarditis or an arthritis resulting from rectal gonorrhea have been reported, yet it would be well for the internist to bear in mind that an examination of the rectum might furnish the clue in a baffling case, where the etiological factor is missing.

Operation for Anal Pruritus.—(Thos. Chas. Martin. M. D., of Washington, D, C.)—The use of a solution of cocain and adreualin secures local anesthesia and a dry visible field. Radiating incisions do not endanger the nutrition of the parts. Corrugation of the flaps may be effaced by eruction of their margins; A skin tag may be removed within an eliptic iucision, which by suture may be given a linear form. Radiating wounds require no suture, coaptate automatically when the patient is in extension and heal by first intention.

MEDICAL SOCIETY OF THE MISSOURI VALLEY.

Twenty-second Annual Meeting held at Council Bluffs, Iowa, Sept. 9-10, 1909.

The President, Dr. C. B. Hardin, Kansas City, Mo., in the chair.

Cancer: A Constitutional Disease; Its Rational Treatment.—Dr. John E. Summers, Omaha, delivered the address on Surgery, selecting this subject. He referred to recent investigations concerning the medical and surgical treatment in cases of cancer of the genitalia, etc., and said:

Technic. First, curette thoroughly and dry carefully, then pour one-half ounce of acetone through a Ferguson speculum (with patient in the Trendelenburg position). Leave this in for fifteen or twenty minutes, then let the acetone run out and pack the cavity with gauze soaked in acetone. Wash the vulva and vagina; insert tampon. In rectal cancer, follow a like practice, only first introduce tampon above growth before using acetone. Repeat the use of acetone two or three times a week in office practice. Protect the vulva with vaselin. By this treatment the oozing is checked, and the wound surface is covered with a thin white film. The odor is remarkably reduced. The discharge is at first watery and then disappears. The wound shrinks and tends to heal. The health improves. The opsonic index is raised.

Acetone bisulphite is a white powder which, dissolving in the wound, gives off pure acetone, and may be used in place of acetone; its method of application is after the same fashion. Besides escharotics, the the x-ray and radium, which, when the cancer or sarcoma can be reached tend to destroy or inhibit its growth, there are certain drugs of great value in the internal treatment of cancer. They are mostly of the alterative type, and usually are best given hypodermically. Certain preparations of arsenic, mercury and iron are to be commended. Iodin, I have not found so useful, but it has its friends. Having noted the fact that cancer never begins primarily in bone, that sarcomas in which the bone element predominates are least malignant, it occurred to me that if, in any way, I could increase or overload the blood with lime, it would be a rational therapeutic measure in the treatment of malignant disease as a postoperative measure of prophylaxis and as a remedial agent in conjunction with the hypodermic use of alteratives. So far, I have reason to believe that there is value in the remedy—so much do I think so, that I hope my friends will try it. I use the lactate of calcium given, to begin with, in a hypodermoclysis, from 30 grains to 1 dram in a pint of warm sterile water. Later I continue the drug in doses of from 10 to 30 grains given by the stomach in hot water, thrice daily; it may be continued indefinitely, but at the beginning is apt to cause nausea, Thirty grains of the lactate in a pint of warm water may be given directly into a vein. In a hopeless case of cancer of the throat I found that this drug materially lessened the pain.

Diagnosis and Treatment of Gastric Ulcer with Reference to the Lenhartz Diet.—Dr. Leroy Crummer, Omaha: We can claim the following advantages for the Lenhartz treatment: First it is more comfortable for the patient. Second, there is less loss of weight and nutrition. Third, the period of return to normal diet is shorter. Fourth, the tendency to relapse is less. Till the last few years, the treatment has always been medical, but recently surgical treatment has slipped into the foreground to a great extent. The most conservative surgeons have generally advised operation only after medical means have failed, but that even these restrictions are not enough is now recognized. I have had the opportunity to carry out the Lenhartz treatment in eight cases of gastric ulcer, five of which were comparatively simple cases, and the treatment was successful without modifying any of the details. One patient went through the treatment with seeming complete success and left the hospital greatly improved in weight and strength, but died suddenly one month later with some acute abdominal trouble, probably perforative peritonitis. The other two patients, in addition to the clear ulcer conditions presented severe anemia and signs of pyloric obstruction. For the results of pyloric ulcer, surgical treatment is often demanded, and in general the opinion has been that operation is indicaled in: First, chronic ulcer per se; second, acute hemorrhage; third, perforation; fourth, pyloric stenosis. The atatement is often made that when medical treatment fails in chronic ulcer, a gastroenterostomy or other operation should be done. This indication, I think, should be revised and stated as follows: No operation should be done in chronic ulcer till the patient has had the benefit of a careful trial with the Lenhartz treatment.

DISCUSSION

Dr. John P. Lord, Omaha: I recall several cases of gastric ulcer in men who are now doing well without having undergone surgical intervention. I speak of this to emphasize the success which attends the expectant treatment of these cases. However, when an operation is indicated in gastric ulcer, it should be performed.

Dr. W. B. Deffenbaugh, St. Joseph, Mo.: In the medical treatment of gastric ulcer it is important to prescribe a diet which is free from irritating material. The average diet contains many things that are imperfectly masticated; they pass over the inflamed area, or through the pylorus, and keep up a mechanical disturbance.

Dr. R. C. Moore, Omaha: In my experience, comparatively few cases present the

claasical symptoms of gastric ulcer, but when we have one of these cases, diet is the main thing to consider. I do not resort to feeding by the rectum. I keep the patient as quiet as possible, maintain the action of the different secretory organs as best I can and place the patient on such food as can be digested. Milk should be the main article of diet. When the case takes on a surgical aspect, operation should be considered, and performed if necessary.

Dr. W. L. Ross, Omaha: Gastric troubles are functional and not organic, and we should not be in too great haste in saying that this or that patient has ulcer of the stomach, simply because he or she complains of pain. The whole symptomatology should be gone over in order to determine whether the cause is really located in the stomach or not.

Splenectomy.—Dr. W. B. Deffenbaugh, St. Joseph, reported a case of traumatic rupture of the spleen, in which he resorted to splenectomy, with a successful result.

DISCUSSION

Dr. I. U. Parsons, Malvern, Iowa: Several years ago a boy ten years old fell across a wash-tub, striking himself in the region of the spleen. Several physicians saw the child, but were unable to make a correct diagnosis. Two months after the injury a tumor developed in that region. The abdomen was opened, and a large cyst of the spleen was found and drained. The boy recovered.

Dr. A. C. Stokes, Omaha: The spleen, according to German authority, has a physiologic function. It has to do with infections in the production of immunity, or the swallowing up of infections. This is illustrated by the fact that so many patients who have had infectious diseases have enlargement of the spleen. Embrologically, from the standpoint of comparative anatomy, the spleen seems to be more of a remnant than anything else, for in animals it is much larger in comparison with the body-weight than it is in man. The blood supply seems to be about the same.

Unrecognized Gall-Stone Disease.—Dr. Daniel Morton, St. Joseph, Mo.: In this paper I discuss neuralgia of the stomach, biliousness, autointoxication, nervous symptoms, pain in the gall-bladder, referred pain, vomiting, colic, tumor, jaundice, gall-stones and cancer of the gall-bladder. Let us not be deceived with the belief that gall-stones represent the final stage of gall-stone disease. It is now conceded and statistics prove that the frequent concurrence of gall-stones and malignant disease is not accidental, but that the former by their irritation produce the latter. I mention this fact in order that I may emphasize the necessity for early recognition of gall-stone disease. Courvoisier found 72 cases with gall stones in 84 cases of primary gall-bladder cancer. Possibly, the inaugural symptoms of gall-stone disease may be best brought to the attention of general practitioners by stating that cases of "indigestion," "biliousness," "neuralgia of the stomach," "gastralgia" and "autointoxication" are, in the majority of cases, in reality, cholecystitis, and should be recognized and treated as such. The diagnosis can usually be confirmed by a physical examination of the gall-bladder and a search for the pressure pain points described. The symptoms which heretofore have been considered inaugural, for instance, stone colic and jaundice, are really terminal and are found only after the disease has been long existent and indicate a late stage of the disease.

Our knowledge of cholecystitis is increasing rapidly not only as a pathologic condition affecting the gall-bladder alone, but also affecting the liver itself and the pancreas. We are also discovering that the stomach is a much maligned organ and that it has heretofore been charged with offenses of which it was guiltless and for which its nearby neighbor, the gall-bladder has been proved responsible. In a word the gall-bladder as an important factor in the causation of trouble in the organs adjacent is assuming a rapidly increasing important role. In the beginning of gall-bladder surgery attention was directed to the organ itself and it was made the objective point of all surgical measures. But it was found that with the relief of the pathologic condition in the gall- bladder not only was the original purpose, for which the operation was done accomplished, but in addition, over and above this, symptoms disappeared which had formerly been attributed to other organs. Putting operative findings and clinical together, thetefore, a number of obscure abdominal disturbances are coming out of the darkness of ignorance into the light of scientific knowledge.

DISCUSSION

Dr. John Monroe, Bannister, Omaha: I would like to relate my experience in the Philippines in reference to this line of work. Conditions of extreme congestion of the liver and enlargement are not found in the United States as they are in the tropics; consequently a diagnosis of enlarged gall-bladder is

easy. While in the Philippines I did a large amount of surgical work. There were cases of liver disease to treat, and in the number of patients operated on there was not a single case of disease of the gall-bladder. Frequently disease of the gall-bladder was suspected, but in these cases the livers would be so enlarged from passive or active congestion as to fill the abdominal cavity. It was a rule in suspicious cases to perform laparotomy as a routine measure, going in, getting the enlarged liver out of the way, exploring and examining the gall-bladder to see if there was anything the matter with it. It was found that the livers of these patients were very much congested and enlarged. It was also a rule to aspirate the liver and if an abscess was not found a good deal of blood was drawn off; but these patients invariably did well.

Dr. A. I. McKinnon, Lincoln, Neb.: It is possible to have billary or gall-stone colic without the presence of gall-stones. Gall-stones are due ordinarily to infection. Cholecystitis frequently accompanies infectious diseases, and many times the trouble begins in childhood, following some infectious disease. When there is an acute cholecystitis, for instance, complicated with pneumonia, there is jaundice, and as the growth of fibrous tissue replaces the exudate, contraction takes place, and obstruction to the bile tracts occurs.

Dr. A. B. Somers, Omaha: The removal of the gall-stones does not always relieve or cure the primary condition which still exists, and the patient should be taught to go to a physician when he gets through with the surgeon, unless the surgeon is also a physician.

Dr. W. F. Milroy, Omaha: I want to go one step further than the last speaker, and say that these patients should go to see a physician before consulting a surgeon, as I am firmly convinced that most of these individuals can be cured by medical treatment and require no operation whatever.

Surgical Suggestions for the Treatment of Chronic Appendicitis.—Dr. A. I. McKinnon, Lincoln, Nebr. In this paper I recommend that the incision be made high enough for examination of the upper abdomen and treatment of those parts which may be found involved. This incision can be made about the same as a gall-bladder incision, the lower end being even with the umbilicus, or at a point where most authorized incisions begin. Through such an opening, the appendix can be easily pulled up and with the aid of a proper position of the patient the whole abdomen and pelvis will be open for examination. For further facilitaing this exploration, I advocate the sitting posture of the patient. This not only allows complete exploratton, but permits it to be done through a small incision. I have used this posture for several years with great success in handling the abdominal viscera. Chronic appendicitis often either complicates or is complicated by a pathologic condition of the upper abdomen, which, if overlooked, will lead to continued trouble on the part of both patient and surgeon.

Scientific Feeding.—Dr. Linda A. McLintock, Atchison, Kansas: Man is said to be the net product of what he eats and drinks. Food bears the same relation to him that soil does to vegetation. No man can do his best physically who is underfed. A celebrated chemist says: "If we could ascertain perfectly the demands of the human body and supply perfectly those demands, life might be prolonged indefinitely." He enjoys the best health, the keenest mentality, the highest physical powers who can select for himself those articles of diet that will most nearly supply all the constituent parts of the body in natural proportions. To do this: First, food must contain all the nutritive elements the body requires. Second, only such foods should be combined at each meal as will produce chemical harmony in the stomach. Third, food must be proportioned so that the body will not be overfed with certain elements of nutrition and underfed with others. No less important is the observance of natural laws or idiosynerasies, namely, age, sex, temperament, environment, together with the season of the year, occupation, exercise, etc.

[To be continued.]

Opium Famine in San Francisco.—San Francisco's Chinatown for the first time in its history is threatened with an opium famine. Two important factors have contributed to bring about this condition. The United States Government, by absolutely prohibiting the importation of opium in a crude form, has sent the price soaring from $16 to $40 for a half pound tin, while the State Board of Pharmacy, by strict supervision of all drug stores and prompt punishment of all offenders caught selling opium in any form, has made it impossible to obtain morphine in any place in San Francisco except on a doctor's certificate. This has resulted in a great hardship to the slaves of the drug, many of whom have applied for admission to insane asylums where they may be cured of the habit.

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scentific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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MEDICAL MISCELLANY

Foreign Medical Students in Japan.—It is said that the number of medical students from foreign countries applying for admission to the medical colleges of Japan is steadily increasing. Heretofore there have been no prescribed standards regulating the admission of such students, but hereafter candidates will be expected to understand the Japanese language and have attainments not lower than graduates of the Japanese High Schools. It is also proposed to make Japanese the sole language for the examination of physicians.

A National Conference on Pellagra will be held in Columbia, S. C., on November 3 and 4, 1909, under the auspices of the South Carolina State Board of Health. Physicians and sanitarians are cordially invited to attend. Although the malady is of comparatively recent recognition in this country, it has already manifested itself in seventeen States, and is assuming the proportions of a national public health problem. The conference will include not only addresses, papers, and discussions, but a number of clinical cases will be represented, thus affording an excellent opportunity for a study of the disease. Information can be obtained by writing Dr. C. F. Williams, secretary of the South Carolina State Board of Health, Columbia.

New York and New England Association of Railway Surgeons will hold its nineteenth annual meeting at the Academy of Medicine, New York City, on November 16, 17, 1909. A symposium will be presented on the "Causes of Railway Accidents Individualized." The names of prominent lay officials, attorneys, and surgeons from railways all over the country appear on the program, which is very attractive and interesting. All interested in this line of work are cordially invited to attend. George Chaffee, Corresponding Secretary, 338 47th street, Brooklyn, N. Y.

A Medical Officer May Command.—The controversy over the assignment of a medical officer to actual command of a hospital ship, which caused the resignation of Rear Admiral Brownson from the Bureau of Navigation in 1908, has again been revived. The Secretary of the Navy has asked an opinion as to the legality of such an assignment and Attorney General Wickersham has rendered an opinion to the effect that a medical officer not below the grade of surgeon can legally be assigned to the command of a hospital ship. It is understood that the chief of the Bureau of Navigation will probably recommend that a line officer be put in command, while Surgeon General Rixey will urge the assignment of a medical officer. In the opinion rendered the attorney general specifically refrained from any discussion of the merits of the question as to whether or not a medical officer should be put in command, but merely stated that such a detail was legal and in accordance with the regulations. The question will arise in the near future in connection with the Solace, which is now being fitted out at Charleston Navy Yard as a hospital ship for the Atlantic fleet. Neither the President nor the Secretary of the Navy has given any indication of the course they will pursue in the matter.

The President of the American Gynecological Society has appointed a committee to report at the next annual meeting in Washington, on the Present Status of Ob-

stetrical Teaching in Europe and America, and to recommend improvements in the scope and character of the teaching of obstetrics in America. The committee consists of the professors of obstetrics in Columbia University, University of Pennsylvania, Harvard, Jefferson Medical College Johns-Hopkins University, Cornell University and the University of Chicago. Communications from anyone interested in the subject will be gladly received by the chairman of the committee, Dr. B. C. Hirst, 1821 Spruce street, Philadelphia, Pa.

Pellagra.—Dr. William Francis Drewry (Virginia Medical Semi-Monthly, Sept. 24, 1909) reports upon 14 cases of pellarga which have been under observation at the Virginia Central State Hospital for the past year. This strange and fatal disease has been prevalent in Italy for about 200 years, but has only recently made its appearance in some of the Southern sections of our country. It is characterized mainly by gastro-intestinal disorders, stomatitis, dermatitis on the parts of the body exposed to the sun, and various mental and nervous phenomena, principally depression, and in some cases symptoms referable to spinal degeneration. There may be remissions and exacerbations. This is true in chronic cases. The disease has not so far been considered contagious, nor communicable. Some observers, however, believe it to be infectious. It is not hereditary. Persons between the ages of 20 and 40 are more liable to have it, though children and elderly people are not exempt. Infants seem to be immune. It is not confined to the poorer classes. The statistics indicate that women are oftener affected than men. The symptoms manifest themselves mostly in spring and summer. As to its etiology there is much doubt, but the generally accepted theory is that it is caused by eating diseased corn. The prognosis is unfavorable. The typical fulminating type is hopeless. In the chronic or recurring type—those having the annual spring and summer attacks—the symptoms may subside, but return at the elected season. Authorities and observers vary in their opinion as to the length of time a person having pellagra may live—from a few months to several years. In the treatment the diet of pellagrins should be free from any of the products of Indian corn. A generous and nutritious dietary should, however, be given, and the hygienic conditions made as sanitary and as perfect as possible. As to therapeutic measures, no remedy so far used seems to be of much value. Tonics, such as strychnine, iron, quinine, arsenic, cod liver oil, etc., are usually employed with possibly some benefit in a few cases. Atoxyl (a form of arsenic) is said to have been used by some physicians with marked benefit. Of the 14 cases reported, 5 died, 2 have recovered, or rather are temporarily without symptoms except of dementia, and in 7 the disease is still active. The clinical report and pathological and post-mortem findings of but one case are given in this paper, the rest are promised in the next issue.

Railway Surgeons Meet.— The seventh annual meeting of the Pacific Association of Railway Surgeons was held in San Francisco, August 27 and 28, and the following officers were elected: President, Dr. Carl Kurtz, Los Angeles; vice-presidents, Drs. Oliver D. Hamlin, Oakland, Thomas B. Reardan, Oroville; secretary, Dr. George R. Carson, San Francisco; treasurer, Dr. Ernest M. Keys, Alameda, and member of executive board, Dr. David Powell, Marysville.

For the Tuberculous Patient.—Physicians having patients who need change of climate will learn something of interest by addressing Dr. A. S. Ashmead, Canadensis, Monroe Co., Pa.

Risiccol (Castor Oil Powder).—That so satisfyingly effective a remedy as castor oil is so nauseatingly objectionable to the patient has often prohibited its use where it, more than any substitute, was indicated. This has led to numerous efforts to disguise the oil and render it palatable, in most of which palatableness has proven a misnomer or has been gained at the expense of utility. The English profession has been using a powdered castor oil for some years which meets all the requirements, being practically without taste and containing 50 per cent pure castor oil. The substance added is inert and serves but two purposes, that of making a stable powder and disguising the taste of the oil. It has been given the name risiccol (Siccolum Ricini), it is easily taken in its original form, or it may be added to milk, porridge or other liquid or semi-liquid food. Risiccol promises to become an agent generally used by the American profession.

Cystitis.—

Uritone	3ij
Lithii benzoat	3ij
Elix. uritone comp	3vj

M. Sig.: Two teaspoonfuls in water three times daily.

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From the moment the ingredients are placed in the specially designed compounding machine until the nurse removes the finished product from the sterilized container at the bedside, every move in the making is done by machinery and under the most rigid antiseptic precautions. By preventing exposure it is possible to conserve to the highest possible degree ANTIPHLOGISTINE'S hygroscopic properties.

No plastic dressing can be mixed in a mortar box with a hoe or in an ice cream freezer or even with a druggist's mortar and pestle and possess any scientific value. Its hygroscopic and osmotic qualities are necessarily ruined, owing to absorption of atmospheric moisture.

In using ANTIPHLOGISTINE, the ORIGINAL and ONLY antiseptic and hygroscopic plastic dressing on the market, the physician knows that he is getting the BEST. Years of experience, specially designed machinery, a perfect container and the knowledge how, when and why, enable the originators of ANTIPHLOGISTINE to turn out a remedial agent which in kind has never been equalled in the history of pharmaceutical manufacturing.

The wise medical man who believes in ORIGINAL products, which are always the BEST products, prescribes

ANTIPHLOGISTINE

(Inflammation's Antidote)

The Denver Chemical Mfg. Co., New York.

A Delightful Revelation

The value of senna as a laxative is well known to the medical profession, but to the physician accustomed to the ordinary senna preparations, the gentle yet efficient action of the pure laxative principles correctly obtained and scientifically combined with a pleasant aromatic syrup of Californian figs is a delightful revelation, and in order that the name of the laxative combination may be more fully descriptive of it, we have added to the name Syrup of Figs "and Elixir of Senna," so that its full title now is "Syrup of Figs and Elixir of Senna."

It is the same pleasant, gentle laxative, however, which for many years past physicians have entrusted to domestic use because of its non-irritant and non-debilitating character, its wide range of usefulness and its freedom from every objectionable quality. It is well and generally known that the component parts of Syrup of Figs and Elixir of Senna are as follows:

Syrup of Californian Figs..... 75 parts
Aromatic Elixir of Senna (manufactured by our original method, known to the California Fig Syrup Co. only).... 25 parts

Its production satisfied the demand of the profession for an elegant pharmaceutical laxative of agreeable quality and high standard, and it is, therefore, a scientific accomplishment of value, as our method ensures that perfect purity and uniformity of product required by the careful physician. It is a laxative which physicians may sanction for family use because its constituents are known to the profession and the remedy itself proven to be prompt and reliable in its action, acceptable to the taste and never followed by the slightest debilitation.

ITS ETHICAL CHARACTER.

Syrup of Figs and Elixir of Senna is an ethical Proprietary remedy and has been mentioned favorably, as a laxative, in the medical literature of the age, by some of the most eminent living authorities. The method of manufacture is known to us only, but we have always informed the profession fully, as to its component parts. It is therefore not a secret remedy, and we make no empirical claims for it. The value of senna, as a laxative, is too well known to physicians to call for any special comment, but in this scientific age, it is important to get it in its best and most acceptable form and of the choicest quality, which we are enabled to offer in Syrup of Figs and Elixir of Senna, as our facilities and equipment are exceptional and our best efforts devoted to the one purpose.

California Fig Syrup Co.,

Addresses:

San Francisco, Cal.
U. S. A.

Louisville, Ky.

New York, N. Y.

London, Eng.

SOCIETY PROCEEDINGS

MEDICAL ASSOCIATION OF THE SOUTHWEST.

Annual Meeting, San Antonio, Texas, November 9, 10, 11, 1909.

The physicians of the Central West and Southwest are looking forward to this event with more than usual interest and enthusiasm, not alone on account of the many attractions of a trip to Texas and Mexico, but because of the excellent scientific program which the secretary and section officers of this body may always be depended upon to supply. We are pleased to present in this issue the preliminary program in which will be found such a variety of subjects that all may be sure of a treat, whether they be general practitioners or specialists.

The principal addresses of this meeting will be delivered by Dr. M. L. Harris, of Chicago, and Dr. Geo. Dock, of New Orleans, which announcement presages an evening of rare scientific enjoyment.

PRELIMINARY PROGRAM.

Tuesday, November 9, International Club Rooms.

10:30 a. m. General session and addresses of welcome and responses.
Meeting of Executive Committee.
2 to 6 p. m. International Club Rooms, scientific section work.
8 to 10 p. m. International Club Rooms, general session.
The President's Annual Address, Dr. Jabez N. Jackson, Kansas City, Mo.
Oration on Surgery, Dr. M. L. Harris, Chicago, Ill.
Oration on Medicine, Dr. Geo. Dock, New Orleans, La.
10 to 12 p. m. Stag social and smoker.

Wednesday, November 10, International Club Rooms.

8:30 to 9:30 a. m.. General session.
9:30 to 12. Scientific section work.
2 to 3 p. m. The Medical Association of the Southwest meeting with the Fifth District Medical Association; an oration of general interest and the election of district officers.
3 to 6 p. m. Scientific section work.
8:30. Reception and banquet for the doctors and visiting ladies.

Thursday, November 11, International Club Rooms.

8:30 to 9:30 a. m. General session, reports of officers and all committees.
9:30 to 11 a. m. Scientific section work.
11 a. m. to 1 p. m. Election of officers, selection of place for next meeting, etc., and adjournment.
3 to 5 p. m. Automobile ride over city for the doctors and visiting ladies.
Committee meetings will be called as far as possible so as not to conflict with the work of the scientific sections.
Special excursion to "City of Mexico" will leave at 1 a. m., November 13.
Sleepers will be ready for occupany after 9:30 p. m., so that those desiring to do so may retire at the usual time.

Program for Section on Surgery.

Chairman, J. A. Foltz, Fort Smith, Ark.
Vice Chairman, R. H. Barnes, St. Louis, Mo.
Secretary, E. H. Martin, Hot Springs, Ark.
Some Observations of the After Treatment of Abdominal Section, C. A. Thompson, Muskogee, Okla.
Abdominal Operation: Preparation and After Care, Howard Hill, Kansas City, Mo.
Vesico Abdominal Fistula, Le Roy Long, So. McAlester, Okla.
Paper, subject to be announced, D. A. Myers, Lawton, Okla.
Consideration of the Operative Patient, H. C. Crowell, Kansas City, Mo.
Some Takes and Mistakes as Demonstrated by the X-Ray, E. S. Lain, Oklahoma City, Okla.
Tubercular Fistula in Ano, with report of cases, E. H. Thrailkill, Kansas City, Mo.
Surgical Considerations of the Pneumococcus, Dr. Blesh, Oklahoma City, Okla.
The Pathological Aspect of the Pneumococci in Surgical Cases, Clarence E. Lee, Oklahoma City, Okla.
Osteophites of the Oscalsis, J. D. Griffith, Kansas City, Mo.
Myomectomy of Large Fibroids, J. W. Frick, Kansas City, Mo.

Retroperitoneal Shortening of the Round Ligaments, W. E. Dicken, Oklahoma City, Okla.

The Value of Surgical Celerity, Chas. Blickensderfer, Tecumseh, Okla.

Tumors of the Breast, F. H. Clark, El Reno, Okla.

Gunshot Wounds of the Abdomen, with report of case, H. L. Snyder, Winfield, Kas.

Non-tuberculous Infections of the Kidney, review of literature and report of cases, C. C. Nesselrode, Kansas City, Kas.

Primary Carcinoma of the Vagina, with report of a case, Jno. T. Moore, Houston, Tex.

Restoration of the Female Pelvic Outlet Based on the Anatomy of the Parts, W. L. Crosthwait, Holland, Tex.

The Classification of Uterine Retro-displacement Cases, with Respect to Treatment, H. S. Crossen, St. Louis, Mo.

Remarks on Floating Kidney with Modified Operation for Its Relief, Adolph Herff, San Antonio, Tex.

The Tendency of Modern Surgery, J. M. Inge, Denton, Texas.

Minor Surgery in Country Practice, D. C. Summers, Elm Spring, Ark.

The Wasserman Reaction, Nettie Kline, Texarkana, Tex.

Fractures of the Femoral Neck, I. C. Chase, Fort Worth, Tex.

A Hitherto Undescribed Operation for Hemorrhoids under General or Local Anesthesia, Wm. Keiller, Galveston, Texas.

Intestinal Obstruction, W. B. Russ, San Antonio, Tex.

My Experience with Formalin according to Murphy, C. M. Rosser, Dallas, Tex.

Acute Dilatation of the Stomach Following an Appendectomy, J. E. Gilcreest, Gainesville, Tex.

Uterine Displacements, J. M. Taylor, Fort Smith, Ark.

Congenital Absence of the Gall Bladder, Geo. W. Cale, St. Louis, Mo.

Program for Section on General Medicine.

Chairman, A. K. West, Oklahoma City, Okla.

Vice Chairman, G. H. Moody, San Antonio, Tex.

Secretary, Louis M. Warfield, Augusta, Ga.

Address from the Chair, A. K. West, Oklahoma City, Okla.

Some of the Newer Phases of the Etiology and Diagnosis of Syphilis, Wm. Frick, Kansas City, Mo.

Sanitary and Moral Prophylaxis, Olive Wilson, Paragould, Ark.

Pellagra, with report of cases, Wilmer L. Allison, Fort Worth, Tex.

Early Diagnosis of Tuberculosis, Theo. Y. Hull, San Antonio, Tex.

The Need for Education on the Question of Sex and Venereal Diseases, Malone Dougan, San Antonio, Tex.

The Diagnostic and Prognostic Possibilities of Blood Pressure Study, D. W. White, Oklahoma City, Okla.

Subject to be selected, K. H. Beall, Fort Worth, Tex.

Program of Section on Eye, Ear, Nose and Throat.

Chairman, F. D. Boyd, Fort Worth, Texas.

Vice Chairman, J. F. Gsell, Wichita, Kas.

Secretary, A. W. McAlester, Jr., Kansas City, Mo.

Address by the Chairman, F. D. Boyd, Fort Worth, Tex.

Paper, subject to be announced, H. C. Todd, Oklahoma City, Okla.

Recent Advances in Surgery of the Accessory Sinuses of the Nose, R. H. Mann, Texarkana, Ark.

Damage Done the Child by Adenoid Growths, J. H. Barnes, Enid, Okla.

When Should Crossed Eyes be Straightened, E. H. Cary, Dallas, Texas.

Special train service has been arranged for from St. Louis and Kansas City via the M. K. & T. R. R. (the "Katy") and special rates as well. Special train will leave St. Louis Sunday, 10 o'clock, a. m., and Kansas City Sunday evening, 6:20 o'clock, arriving at San Antonio, Monday evening, November 8. The equipment of this train will be the finest that the Pullman company can furnish, including sleepers, diner, and observation buffet. Reservations may be made at office in Kansas City, or through Dr. Chas. Wood Fassett, at St. Joseph, by mail. Special rates for the round trip will be in effect, allowing time for the excursion to Mexico. The fare from San Antonio to City of Mexico and return will be $26.60. Ample time will be allowed for sight-seeing in City of Mexico, and for various side trips. Reservations should be made for this trip as early as possible in order that the required number of cars may be secured.